Original Article

'Greater good' versus civil liberties in the United States: Tuberculosis and Seattle's Firland Sanatorium

Christine Crudo Blackburn

Scowcroft Institute for International Affairs, Texas A&M University, College Station, TX, USA.
E-mail: ccblackburn@tamu.edu

Abstract As far back as the late 1700s, peoples in the United States were developing ways to control infectious disease without infringing on Constitutional rights. Despite acknowledgement that an infected person has certain civil liberties, the history of public health law shows that, in many instances, infectious disease isolation and quarantine proved to be scientifically questionable at best. I examine an historical example of such questionable relationship between public health and civil liberties: the locked ward at Firland Sanatorium in Seattle, Washington. Mandatory quarantine at Firland began in the late 1940s and lasted until the facility closed in the early 1970s. Can examining this history enhance understanding of the relationship between "the greater good" and an individual's civil liberties?
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Introduction

Throughout the first part of the 20th Century, tuberculosis — also known then as the White Plague — ravaged communities in the United States. Worldwide, it continues to do so. In 1908, before understanding developed to explain how the disease spread, United States (US) public health officials rated the city of Seattle, Washington's record for fighting it as the worst in the country.[1] Around the turn of the century, rates of new tuberculosis (TB) infection in Seattle were over 10,000 per year. While this is a substantial number, it pales in comparison the current number of new tuberculosis infections throughout the world — mostly in lower-income countries — a number that reached 10.4 million in 2015.[2]

In conjunction with virtually unchecked tuberculosis throughout Seattle, a large population of male transients resided in an area of the city known as 'Skid Row.' Skid Row (located on Yesler Way) was the main street along which logs were transported from the forests at the top of the hill to Henry Yesler's mill at the bottom. Its name derived from the practice of transporting logs by "skidding" them down the hills.[3] Many male laborers who traveled from town to town looking for work lived in this area — under extremely poor conditions and in the midst of rampant alcohol use. Seattle officials believed these conditions perpetuated tuberculosis in the community. Due in large part to the endemic tuberculosis on Skid Row, Seattle resolved to make tuberculosis control the centerpiece of its public health agenda. This mandate began in 1910 and continued for 70 years.

The city's first major step in controlling the disease was construction of Firland Sanatorium. In that facility, health officials could isolate tuberculosis patients from the rest of society. Seattle also began dedicating large sums of money for tuberculosis research. From the late 1940s through the early 1960s, the sanatorium developed some of the most innovative social programs in the country — focusing on alcoholism as a disease rather than a character flaw — but it also constructed the country's first locked ward, a place to forcibly detain patients. The locked ward sparked outrage among patients and civil liberties groups alike, but many in the city believed it necessary to protect the greater population. Was the locked ward at Firland Sanatorium necessary to protect public health or was it a violation of patients' civil liberties? This paper examines that question.

History of Tuberculosis in Seattle

In the mid-1800s through the early 1900 s Seattle served as a frontier town — where laborers could stop and work on the way to find gold in Alaska. From the turn of the century to the years before the second world war, tuberculosis persisted as the leading cause of death in Seattle.[4] With the disease out of control in the city, Seattle founded Firland Sanatorium to isolate tuberculosis patients and, health officials hoped, also to cure them.

When Firland opened in 1910, its 250 beds provided a place for patients with few or no financial means.[1] Because the hospital had only

a small number of beds compared to the number of infected individuals in Seattle, the sanatorium admitted only individuals they believed to be "worth saving."[1] Individuals deemed "worth saving" were those who had a reasonable chance of being cured and had lived in Seattle for a minimum of a year. The residency requirement disqualified much of the transient community from care. During the 1940s, so many doctors and Firland staff left to contribute to the US efforts in the second world war that Firland barely operated. In 1947, however, a new Firland Sanatorium opened with 1350 beds and this large facility eliminated need for a waiting list.[1] Anyone in Seattle needing treatment could find it at Firland, even the transients living on Skid Row.

From the beginning of the anti-tuberculosis efforts, Seattle was progressive in its methods, developing a research laboratory and therapy facilities from the earliest days of the sanatorium. Following the second world war, with economic recovery in full swing, the city passed a tuberculosis hospitalization law. For the first time Seattle would contribute tax dollars to the fight against the disease.[4] Seattle also established connections with the University of Washington Medical School (located in Seattle) to bring greater medical expertise to Firland.

The city made great progress in fighting tuberculosis following the second world war, but high rates of infection persisted in areas most residents considered to be undesirable. Skid Row, where saloons, brothels, and filthy living conditions abounded, was the worst of these[4] even after rates of the disease began to fall throughout the city. "In an era of declining morbidity and mortality from tuberculosis, skid row alcoholics continued to have high rates of disease and were often non-compliant with therapeutic interventions" (p. 97).[4] Tuberculosis treatment non-compliance among Skid Row alcoholics turned much of the focus of post-war tuberculosis control to stopping the spread within this small population.

One of the greatest challenges for Firland staff was tuberculous alcoholics' tendency to leave the hospital against medical advice. Because many in Seattle viewed alcoholism as a disease, Firland staff made early attempts to address the social and psychological aspects of alcoholism along with curing the alcoholics' tuberculosis.[4] Even with this progressive approach, alcoholics at Firland continued to leave against medical advice and proved difficult to control. The staff began to explore new ways to 'treat' tuberculosis alcoholics: this led to

construction of the locked ward. In 1949, Firland opened the first locked ward in the country; it quickly became a model for health departments across the US.[4]

The Locked Ward at Firland

The medical staff at Firland intended to use Ward 6, the locked ward at Firland Sanatorium, sparingly — only as a last resort. As time passed, however, its use became a means to punish "difficult" patients, particularly alcoholics.[1] From its start as a 27 bed ward for men, it expanded in 1954 to 54 beds, including 6 for women.[5] Although public health authorities and the medical team at Firland intended it to be a place of quarantine, many patients remained in the locked ward far beyond their infectious period. By the mid-1950s, Firland had adopted a policy requiring alcoholics to remain hospitalized for 12 months — regardless of their medical condition.[5] Additionally, staff detained patients in the locked ward without any form of legal 'due process' — a constitutional guarantee that legal proceedings will be conducted in a manner that is fair and an individual will be given notice and a chance to be heard before the government can take away his or her life, liberty, or property. As Lerner explained, "this ability to detain persons on the locked ward without a judge's ruling derived from the Health Department's *letters of quarantine*, that stated patients were to remain 'in that section of the Sanatorium designated by the Medical Director…whether or not the patient had active tuberculosis or was an actual public health threat was irrelevant.'"(pp. 129, 132).[4] Thus, in the early days of the locked ward, patients could be detained indefinitely — as long as the Medical Director considered it justified.

As the use of detention increased, some began to question whether it reflected good public health practice or a desire to punish unruly patients. Some Firland patients began to protest their detention. In 1957, the American Civil Liberties Union (ACLU) began an investigation of Firland, but detention policies there did not change until 1965.[1]

Starting in 1965, a local judge began holding hearings at the sanatorium to listen to and analyze the complaints by detained patients. The establishment of a formal hearing process followed US Supreme Court rulings in the cases of *Mapp v. Ohio* and *Miranda v. Arizona*

where federal courts demonstrated a willingness to impose stricter limits on state actions (than on acts of private individuals).[4]

Despite establishment of a formal legal process at Firland, judges who evaluated patient complaints almost always sided with the hospital.[4] Judges did so even when decisions made by the hospital staff did not match accepted hospital practice.

> The fact that Judge Elston largely acted as a rubber stamp for Firland's detention policies should come as no surprise. Despite the gesture of ensuring due process protections for the civil commitment of tuberculosis patients, few persons in Seattle were eager to release potentially infectious Skid Row alcoholics from confinement that physicians indicated was necessary. The Department of Health nearly always won the occasional legal challenge raised by patients (pp. 151–152)[4]

Despite the guise of due process proceedings, civil commitment — or court-ordered institutionalization of an individual — of tuberculosis patients continued, even for those who posed no risk to public health.

By the 1950 s and 1960 s, across the United States tuberculosis prevalence and mortality declined substantially. This improvement was due in large part to the development of antibiotics with the ability to treat tuberculosis. The first antibiotic developed was Streptomycin, but resistance developed very quickly and after only a few months it was no longer effective. Then, in the 1950s, a series of tuberculosis drugs were developed. These included *para*-amino salicylic acid, isoniazid, pyrazinamide, cycloserine, and kanamycin.[6] Multiple drugs allowed for the development of combination therapy, which was significantly more effective, but required a treatment period of 18 months or longer.[6] Thanks to combination therapy, tuberculosis mortality in Washington State declined by more than 60 per cent to 14.9 deaths per 100,000 population in 1950.[7] By the 1960s, tuberculosis had declined from the 7th leading cause of death in the United States to the 15th.[8] Thus, at the time when Firland staff detained increasing numbers of patients, the number of individuals in Seattle infected with tuberculosis was on the decline.

From 1950 to 1970, Firland detained approximately 2000 individuals — almost all alcoholics from Skid Row.[9] By the time the State of Washington relieved Seattle by assuming financial

responsibility for Firland in 1971, one-third of all patients at Firland resided there under quarantine orders.[1] The Sanatorium eventually closed in 1973, partly because of declining need for the facility and partly due to a national trend to integrate tuberculosis patients into mainstream hospitals and outpatient facilities. When Firland closed its doors, the state transferred the remaining 210 patients to Mountain View Hospital in the nearby city of Tacoma to continue their treatment.[1]

US Legal History of the Use of Quarantine and Isolation

Most US law pertaining to the use of mandatory quarantine or non-criminal detention for public health reasons dates back to before 1970.[10] Courts from an earlier era almost always deferred to the state government and several courts even set forth a view in their rulings that the use of 'police power' — a power delegated to states by the 10th Amendment of the US Constitution allowing them to enact measures to protect the safety, health, welfare, and morals of society — should not be subject to judicial review. As a public health law scholar noted, "Most statutes and early court decisions presume the pre-eminence of public health interests over individual's rights, utilizing neither cogent scientific examination of a measure's potential benefit nor legal assessment of unnecessary restriction on individual rights." (p. 463)[11] In a 1918 opinion in *State ex rel. McBride v. Superior Court for King County*, the Washington State Supreme Court ruled that decisions made by the Washington State Board of Health were final and not subject to judicial review.[12] This near total deference to public health officials on matters of mandatory isolation and quarantine led to numerous abuses of police power.

In *Kirk v. Board of Health* (a 1909 case from the Supreme Court of the US state of South Carolina), the city of Aiken had passed a resolution requiring isolation of an elderly woman for leprosy despite the fact that she had been an active member of the community for decades and showed no evidence of contagion.[13] The courts upheld her confinement even though she posed no risk to the public. In 1922, in *Ex parte Company*, the Ohio Supreme Court upheld quarantine of prostitutes, despite a lack of evidence of venereal disease.[14] Until the mid-1940s, the accepted view of US courts was that all "suspected" prostitutes were natural carriers of venereal disease.[11] Cases like *Kirk*

and *Ex parte Company* were typical until the 1970s, when reforms in laws governing mental health paved the way for changes in public health law.[11]

There are several ways in which individuals can challenge a quarantine order, one of which is through a *Writ of Habeas Corpus*. The legal precedent for filing this writ comes from Article 1, Section 9 of the US Constitution that states an individual's right to protection from being held in non-criminal detention cannot be suspended except in cases of rebellion or invasion.[15] Despite the opportunity for quarantined individuals to file *Writs of Habeas Corpus*, such challenges have been frequently denied in cases related to disease control.[15] Christopher Ogolla, an academic with expertise in both law and public health, argued, "the line of historical cases dealing with habeas corpus in quarantine and isolation are identical in their steadfast refusal to overturn quarantine orders." (p. 152)[15]

Although there is a historical reluctance of US courts to overturn quarantine orders, *habeas corpus* has helped to restrain the unbridled power of states to detain people for reasons of public health. In the cases of *Caves v. Hilbert* and *Hill v. Hilbert*, the Oklahoma Court of Criminal Appeals determined that public health authorities do not always exercise their power in scientific and neutral ways.[15] Sometimes, police powers were used to quarantine individuals on moral grounds rather than scientific ones. Findings like those in the *Caves* and *Hill* cases demonstrate need for greater protection of quarantined individuals' civil liberties. Though some argue that due process protections should not be required in quarantine and isolation cases because they may reduce effectiveness of public health measures and increase the danger to the public, the US Supreme Court ruled in *Addington v. Texas* (1979) that civil commitment amounts to a significant deprivation of liberty. Thus, they require 'due process protection,' or the fundamental right to due process.[16] Although US courts continue in most cases to defer to US states on matters of mandatory quarantine, they have implemented greater requirements for proof that such restrictions of action are necessary to protect the public's health.

Due to incremental changes through legal interpretation of US public health law over the last few decades, there must be a 'due process hearing' (an impartial hearing that provides individuals an opportunity to resolve their disputes in a legal setting) shortly after detention of an individual for public health purposes. The state is required to initiate

this hearing, though there is currently no legal requirement to provide the detained individual with a legal advocate.[15] More often than not, cases of non-criminal detention for public health reasons have fallen under the realm of 'substantive due process.' This term refers specifically to whether the "government's deprivation of a person's life, liberty or property is justified by a sufficient purpose" (p. 1501).[17] An important distinction exists between substantive due process and 'procedural due process.' For the latter, the judge considers whether the government followed the proper procedures when taking away an individual's life, liberty, or property. Historically, substantive due process only applied to cases aimed at protecting businesses from governmental interference, but that changed in 1937.[17] Today, there is argument as to whether substantive due process even exists, and the courts have avoided addressing it directly. In *Michael H. v. Gerald D.*, the US Supreme Court noted that only rights previously established could be upheld under substantive due process.[18] Thus, courts have limited the use of substantive due process for all cases, including public health, to instances where the rights are "enumerated in the text, clearly intended by the framers, or there is a tradition of protecting such rights." (p. 1517)[17] These restrictions on substantive due process have made it difficult for individuals detained for public health reasons to successfully argue they have been subjected to unfair deprivation of their life, liberty, or property.

Despite limitations courts have imposed on the use of substantive due process claims, some US scholars have and will continue to argue that the law does allow courts to require stricter stipulations for quarantine. These include: (1) that the individual poses an actual threat to the public; (2) that the intervention — in this case quarantine — is reasonable and effective; (3) that the intervention is conducted in a manner that complies with equal protection and due process; (4) that individuals are provided with safe and comfortable conditions; and (5) that the least restrictive method is used.[19]

Historically, the US legal system has sided with public health departments on issues of forced isolation and quarantine, though courts have increasingly acknowledged that not all public health detention is scientifically justified. The locked ward at Firland, along with the legal history of quarantine detailed above, show that police powers can be abused. As Ogolla argued, "historically, government agents have used health scares as a form of moral panic. Courts must, therefore, guard

against the risk that governmental action may be grounded in popular myths, irrational fears, or noxious fallacies rather than well-founded science." (p. 160)[11] Detaining individuals for reasons more closely related to morality than public health appears to be what happened at Firland during the time the locked ward was in existence.

Application to Modern Epidemics

Infectious disease epidemics have grabbed headlines worldwide over the past decade. From SARS to Ebola to Zika, public health officials have often struggled to come up with the appropriate response to an outbreak. As can be seen from tuberculosis control in Seattle between 1949 and 1973, forced quarantine can be an important part of protecting public health, but it can also be easily abused. Given the historical and modern day use of forced quarantine, how does the experience with tuberculosis in Seattle inform infectious disease response going forward — in the United States and elsewhere?

The first, and most important application is that it is legal and appropriate for public health to limit an individual's civil liberties, but only under specific circumstances. These are incidences in which the disease is highly virulent, highly deadly, easily transmitted, and/or little understood. There must be scientific justification for both quarantine and isolation. If there is no scientific justification for forcibly detaining an individual, then the detained individual's civil liberties have been violated. Analyzing US legal cases shows that allowing unfettered authority to impose forced quarantine, without adequate or unbiased oversight, leads to abuse of power and violation of civil liberties. In the US, even where detention may be permissible, a due process hearing should be conducted within five days of confinement. Those detained should also have a legal right to be represented by a lawyer, as is the situation for those in the US detained for criminal charges. These same legal protections should also be provided to quarantined individuals in countries throughout the world. Highly infectious diseases could pose challenges to the hearing process, but advances in technology (use of Skype or Google Hangouts) would allow such people to bring their cases before a judge without endangering the general population.

Individuals convicted of a crime in the US may not be held indefinitely without evidence of guilt or other forms of due process.

The same should be true for individuals exposed to infectious disease. We must learn from the experience of tuberculosis at Firland and continue to work to integrate due process and scientific justification into legal reforms of forced quarantine for all infectious diseases in the US and around the world.

About the Author

Christine Crudo Blackburn, PhD is a Postdoctoral Research Fellow at the Scowcroft Institute for International Affairs in the Bush School of Government & Public Service at Texas A&M University.

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